ROSEBUD HEALTH CARE SYSTEMS, INC.
WHITE RIVER HEALTH CARE CENTER
PO BOX 310
WHITE RIVER SD 57579
PH. 605-259-3161 FAX 605-259-3106

APPLICATION FOR EMPLOYMENT

PERSONAL

LAST NAME FIRST NAME MIDDLE	DATE
PO BOX OR STREET ADDRESS	HOME TELEPHONE
CITY, STATE, ZIP	OTHER TELEPHONE
HAVE YOU EVER BEEN EMPLOYED WITH US?	SOCIAL SECURITY #
POSITION DESIRED	PAY EXPECTED
ARE YOU ABLE TO WORK FULL TIME? Y N IF NO, WHAT HOURS CAN YOU WORK?	DATE OF BIRTH
ARE YOU ELIGIBLE FOR WORK IN THE UNITED STATES?	WHEN WILL YOU BE AVAILABLE TO BEGIN WORK?
OTHER SPECIAL TRAINING OR SKILLS: (LANGUAGES, MACHINE OPERATIONS, ETC.)	
ARE YOU A UNITED STATES CITIZEN?	
HOW LONG AT PRESENT ADDRESS?	
ARE YOU OVER 18 YEARS OF AGE? Y N IF NOT, EMPLOYMENT IS SUBJECT TO VERIFICATION OF AGE.	
STATE NAMES OF RELATIVES AND FRIENDS WORKING FOR US.	
HAVE YOU BEEN CONVICTED OF A VIOLENT CRIME ? Y N IF YES, DESCRIBE IN FULL.	

EDUCATION:

SCHOOL	NAME AND LOCATION OF SCHOOL	COURSE OF STUDY	# OF YEARS	DID YOU GRADUATE?	DEGRE DIPLO
GRADUATE					
COLLEGE					
BUSINESS/TRADE/ TECHNICAL					
HIGH SCHOOL					
ELEMENTARY					

MEMBERSHIP IN PROFESSIONAL OR CIVIC ORGANIZATIONS:

EMPLOYMENT: (PLEASE GIVE ACCURATE, COMPLETE FULL-TIME AND PART-TIME EMPLOYMENT RECORD. START WITH YOUR PRESENT OR MOST RECENT EMPLOYER.)

COMPANY NAME	TELEPHONE:
ADDRESS:	EMPLOYMENT DATES FROM: TO:
NAME OF SUPERVISOR:	WAGE: START: END
STATE JOB TITLE AND DESCRIBE YOUR WORK:	REASON FOR LEAVING:
PREVIOUS EMPLOYER CONTACTED DATE: BY WHOM:	FAVORABLE OR UNFAVORABLE

COMPANY NAME:	TELEPHONE:
ADDRESS:	EMPLOYMENT DATES: FROM: TO:
NAME OF SUPERVISOR:	WAGE: START: END:
STATE JOB TITLE AND DESCRIBE YOUR WORK:	REASON FOR LEAVING:
PREVIOUS EMPLOYER CONTACTED DATE: BY WHOM:	FAVORABLE OR UNFAVORABLE

COMPANY NAME:	TELEPHONE:
ADDRESS:	EMPLOYMENT DATES: FROM: TO:
NAME OF SUPERVISOR	WAGE: START: END:
STATE JOB TITLE AND DESCRIBE YOUR WORK:	REASON FOR LEAVING:
PREVIOUS EMPLOYER CONTACTED DATE: BY WHOM:	FAVORABLE OR UNFAVORABLE

WE MAY CONTACT THE EMPLOYERS LISTED ABOVE UNLESS YOU INDICATED THOSE YOU DO NOT WANT US TO CONTACT.

YOU MUST SIGN THIS APPLICATON. READ THE FOLLOWING CAREFULLY BEI
YOU SIGN.

A FALSE STATEMENT TO ANY PART OF YOUR APPLICATION MAY BE GROUNI
FOR NOT EMPLOYING YOU OR FOR DISMISSING YOU AFTER YOU BEGIN WOR

IT IS MY UNDERSTANDING THAT THE WHITE RIVER HEALTH CARE CENTER W
MAKE A THOROUGH INVESTIGATION OF MY ENTIRE WORK HISTORY AND MA
VERIFY ALL DATA GIVEN IN MY APPLICATION FOR EMPLOYMENT, RELATED
PAPERS, OR ORAL INTERVIEWS. I AUTHORIZE SUCH INVESTIGATION AND TH
GIVEN AND RECEIPT OF ANY INFORMATION REQUESTED BY THE WHITE RIVE
HEALTH CARE CENTER AND I RELEASE FROM LIABILITY ANY PERSON GIVINC
RECEIVING ANY SUCH INFORMATION. I UNDERSTAND THAT FALSIFICATION
DATA SO GIVEN OR OTHER DEROGATORY INFORMATION DISCOVERED AS A
RESULT OF THIS INVESTIGATION MAY PREVENT MY BEING HIRED, OR IF HIRE
MAY SUBJECT ME TO IMMEDIATE DISMISSAL.

IN THE EVENT OF EMPLOYMENT, I UNDERSTAND THAT FALSE OR MISLEADIN(
INFORMATION GIVEN IN MY APPLICATION OR INTERVIEWS MAY RESULT IN
DISCHARGE. I UNDERSTAND ALSO, THAT I AM REQUIRED TO ABIDE BY ALL
RULES AND REGULATIONS OF THE EMPLOYER.

I CERTIFIY THAT, TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL MY
STATEMENTS ARE TRUE, CORRECT, COMPLETE AND MADE IN GOOD FAITH.

SIGNATURE OF APPLICANT DATE

PLEASE PROVIDE TWO FORMS OF ID WITH THIS APPLICATION.